Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss modifications to Medicare's method for updating its payments to physicians, which in 2001 totaled about $41 billion.[1] As you know, more than a decade ago to control rapid increases in Medicare spending for physician services, the Congress implemented a physician fee schedule and a fee update formula to moderate spending growth relative to specified spending targets. These spending targets increase annually to account for growth in the costs of providing physician services, the growth in the overall economy, and changes in the number of Medicare beneficiaries, while physician fees are adjusted for changes in the costs of providing services and how actual cumulative spending compares to the cumulative targets. In November 2001, however, the Centers for Medicare and Medicaid Services (CMS) announced that updating Medicare's fees for 2002 with this formula will cause the fees to decline 5.4 percent from what was paid in 2001.[2] The Congress has been concerned that fluctuations in physician payments and payment reductions may over the long run jeopardize beneficiary access to physician services. As a result, it asked the Medicare Payment Advisory Commission (MedPAC), which advises the Congress on Medicare payment issues, to study the possibility of eliminating spending targets and modifying the method for updating physician fees.

As you consider refinements to Medicare's method of updating physician payments, it is important to remain mindful of the need to ensure Medicare's sustainability for future generations of beneficiaries. In view of the coming surge in the Medicare-eligible population through the aging of the baby boom generation, projected program spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Furthermore, the slowdown in Medicare spending growth we saw in recent years appears to have ended. At the same time, the fiscal discipline imposed on provider payments continues to be challenged, and interest in modernizing the Medicare benefit package to include prescription drug coverage and catastrophic protection has increased. Together, these developments will impede efforts to achieve the fiscal restraint that the Comptroller General and others have warned is essential to the program's sustainability.

In the context of these broader interests, I will discuss (1) Medicare's use of spending targets as a means of moderating the growth in physician service expenditures, (2) the factors used in computing those targets that resulted in the reduced fees for 2002, and (3) adjustments to determining and applying spending targets that could moderate swings in physician fees, while ensuring payments are adequate to maintain physicians' ability to provide high-quality care to Medicare beneficiaries. My comments are based on previous and ongoing work on Medicare spending trends and Medicare payment methods, including the physician fee schedule.

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[1]The $41 billion represents total Medicare payments to physicians, including beneficiary cost sharing. This statement refers to both calendar and fiscal years. We will use "fiscal year" where appropriate; other references to years, except where noted, are to calendar years.

[2]Until June 2001, CMS was known as the Health Care Financing Administration (HCFA). We will continue to refer to HCFA when referring to the organizational structure and operations associated with that name.

In brief, moderating Medicare's spending growth on physician services while setting payment rates adequate to ensure beneficiary access to care is not a straightforward matter. Medicare spending on physician services grew rapidly through the 1980s, at an average annual rate of more than 12 percent, even though physician fees were subject to some limits. The spending growth was driven by increases in the volume of services provided to each beneficiary and by increases in the intensity of services provided.[3] Recognizing that expenditure growth of this magnitude was not sustainable, the Congress attempted to impose fiscal discipline through a physician fee schedule and a payment update mechanism that incorporates spending targets. Physician fees are updated to reflect the increased costs of providing services with the updates adjusted up or down depending on whether actual spending has fallen below or exceeded the targets. The targets themselves are adjusted annually to account for changes in the costs of providing services, the number of Medicare beneficiaries, and the gross domestic product (GDP). Since the introduction of this fee system in 1992, annual increases in the volume and intensity of services provided per beneficiary have moderated significantly. In 2002 the system resulted in Medicare's physician fees being reduced 5.4 percent below the fees paid in 2001, despite an estimated 2.6 percent increase in the cost of physician inputs.[4] This reduction is to account for historical cumulative spending that exceeded the target by $8.9 billion, or 13 percent of estimated 2002 spending. Several factors contributed to the disparity between actual and targeted spending, including the correction of substantial errors in past spending estimates and the revision of targets for prior years. The current update mechanism could be modified to moderate fluctuations in physician fees and to ensure adequate payments, while retaining the fiscal discipline created by having a spending target. Such modifications would need to balance concerns about preserving fiscal discipline on physician spending with the need to maintain adequate payment rates to ensure that beneficiaries have access to physician services. Because the paramount consideration in setting payment rates is ensuring appropriate beneficiary access to services, timely and detailed data on Medicare beneficiary service use are essential to achieving this balance.

BACKGROUND

Total Medicare spending for physician services depends on actual payment rates, the volume of services provided, and the mix of those services. Medicare spending goes up when the price paid to physicians for each service increases, when the number of services provided rises, or when more intensive, and therefore more expensive, services replace less intensive ones.

[3]The intensity of services is the quantity and quality of resources used in providing them.

[4]Inputs for physicians' services are, for example, staff salaries and overhead.

Since 1992, Medicare has paid for physician services using a fee schedule. The fee for each service is a dollar conversion factor, adjusted to reflect the resources required for that service relative to the resources required to provide all other physician services, and the differences in the costs of providing services across geographic areas.

Along with the fee schedule, the Congress enacted a system of spending targets designed to control growth in total spending for physicians' services. The Sustainable Growth Rate (SGR) system was created in the Balanced Budget Act of 1997 and revised in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA).[5] It replaced the first system of spending targets, implemented in 1992, known as the Volume Performance Standard. The SGR system sets spending targets for physician services and adjusts payment rates to bring spending in line with those targets. The SGR target for total spending is based on spending in an initial, or base, year and the estimated growth in real per capita GDP each year and three other factors that affect overall spending on physician services—the changes in the cost of inputs used to produce physicians' services (as measured by the Medicare Economic Index (MEI)), the number of Medicare beneficiaries in the traditional fee-for-service program, and expenditures that result from changes in laws or regulations.

The spending target for physician payments is applied by incorporating it into the adjustment to the conversion factor that determines the payment amount per service. The conversion factor is determined annually by adjusting the previous year's conversion factor by the change in the MEI, to account for the cost of inputs for physician services, and adjusting this product on the basis of the relationship between the cumulative SGR target and Medicare physician spending. The conversion factor update is greater than the MEI when physician spending has been below the targets and is less than the MEI when physician spending has been higher.

SPENDING TARGETS ESTABLISHED TO MODERATE RAPID RISE IN OUTLAYS FOR PHYSICIAN SERVICES

In response to escalating Medicare expenditures, the Congress made major changes in Medicare payment policies, beginning first by enacting the hospital inpatient prospective payment system, which was implemented in 1983, and then the Medicare physician fee schedule, implemented in 1992. When enacting the fee schedule, the Congress recognized that setting fees alone would not sufficiently restrain physician spending growth. Despite some constraints on physician fees since the 1970s, spending on physician services had grown dramatically in the 1980s as a result of increases in the volume and intensity of services provided. The Congress, therefore, provided that annual physician fee increases would depend upon whether total Medicare physician spending exceeded or fell short of cumulative spending targets. Since the implementation of the fee schedule and spending targets, the rise in Medicare spending

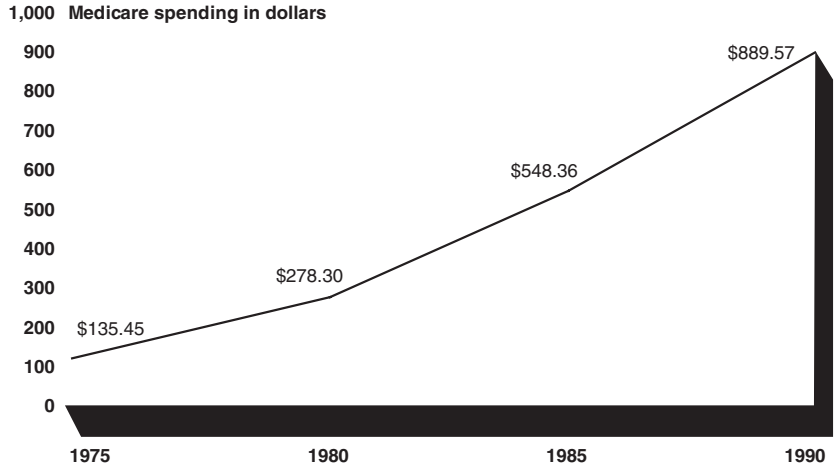
[5]Pub. L. No. 105-33 § 4503, 11 Stat. 251, 433 (to be codified at 42 U.S.C. § 1395w-4(f)). Pub. L. No. 106-113, Appendix F, § 211, 113 Stat. 1501, 1501A-345 (to be codified at 42 U.S.C. 1395W-4)).

for physician services has slowed significantly, reflecting lower growth in the volume and intensity of these services.

Spending on Physician Services Grew Rapidly Before 1992

Before the physician fee schedule was implemented, Medicare payments for physicians' services were largely based on historical charges. Although during the 1970s the Congress introduced some controls on annual payment rate increases, Medicare spending for physician services continued to rise. This was also true in the 1980s—between 1980 and 1990, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of more than 12 percent, tripling from $278 to $890 (see fig. 1).

Figure 1: Medicare Spending for Physicians' Services, per Beneficiary, 1975-1990



Note: Amounts represent Medicare spending, net of beneficiary cost sharing, for the year ending June 30.

Sources: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington, D.C.: Apr. 28, 1998), pp. 51-2; and HCFA, *A Profile of Medicare: Chartbook 1998* (Washington, D.C.: 1998), p. 64.

Much of the spending growth resulted from increases in the volume of services provided to each beneficiary and the substitution of more intensive and expensive services for less intensive and expensive ones. The Physician Payment Review Commission, which was charged with advising the Congress on Medicare physician payment issues, observed, "[b]y the late 1980s. . . volume and intensity growth had become the primary cause of higher program spending. In fact, from 1986 until 1992, while physician payment rates grew by less than 2 percent annually, the volume and intensity of services rose by almost 8 percent per year."[6]

[6]Physician Payment Review Commission, *1995 Annual Report to Congress* (Washington, D.C.: Physician Payment Review Commission, 1995).

The Congressional Budget Office in 1986 stated that "[b]oth the price and the volume of services must be controlled to constrain costs . . .."[7] Spending targets were needed to limit growth in volume and intensity of physician services. In 1989 testimony, Health and Human Services Secretary Louis W. Sullivan said "Medicare physician spending has increased at compound annual rates of 16 percent over the past 10 years. And in spite of our best efforts to control volume and reign in expenditures, Medicare physician spending is currently out of control. . . An expenditure target. . . sets an acceptable level of growth in the volume and intensity of physician services."[8]

Spending Targets Created Incentives to Moderate Growth in Volume and Intensity of Services

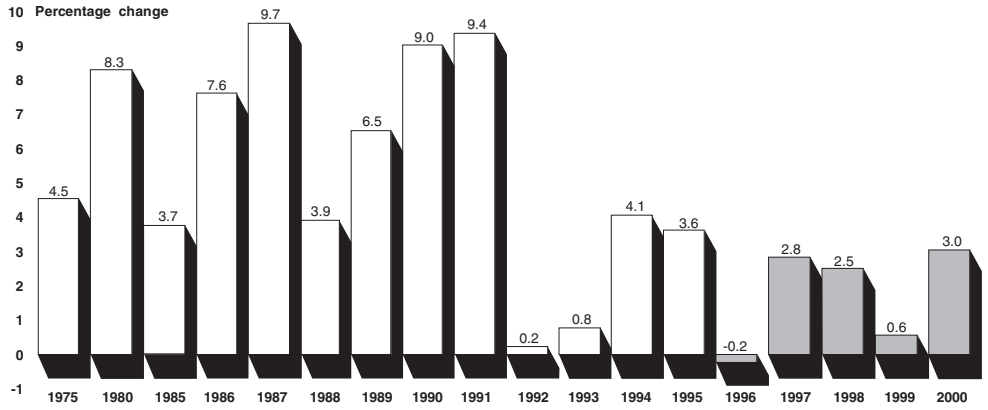
The Congress introduced spending targets for physician services in conjunction with the physician fee schedule in 1992 to help constrain the rise in Medicare spending for physician services. The targets incorporated limited growth in the volume and intensity of services and were revised each year based on estimates of changes in the number of Medicare beneficiaries and physician input prices. If actual spending exceeded the targeted amounts, future payment rates would be reduced, relative to what they would have been if actual spending had equaled the targets, to offset the excess spending. If actual spending fell short of the targets, future payment rates would be increased.

Since 1992, the growth in the volume and intensity of physicians' services per Medicare beneficiary has moderated (see fig. 2). Between 1992 and 2000, the average annual increase in Medicare spending due to changes in volume and intensity of services per beneficiary was about 2 percent. In contrast, between 1985 and 1992, immediately before the introduction of spending targets, volume and intensity of services per beneficiary increased at an average annual rate of about 9 percent.

[7]Congressional Budget Office, *Physician Reimbursement Under Medicare: Options for Change* (Washington, D.C.: Apr. 1986).

[8]Testimony before the Subcommittee on Medicare and Long-term Care, Committee on Finance, U.S. Senate, 101st Congress, 1st Session (June 16, 1989).

Figure 2: Changes in Volume and Intensity of Medicare Physician Services, per Beneficiary, 1975-2000



Notes: Data are for beneficiaries in the traditional fee-for-service program only.

From 1975 through 1995, volume and intensity of services changes are based on Medicare outlays for all physician services. From 1996 through 2000, volume and intensity of services changes are based on Medicare outlays for physician services covered by the fee schedule.

Sources: *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, pp. 51-2; *A Profile of Medicare:Chartbook 1998*, p. 64; and Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Mar. 19, 2001), http://www.hcfa.gov/pubforms/tr/smi2001/tabiig2.htm accessed Feb. 9, 2002.

SEVERAL FACTORS ASSOCIATED WITH 2002 FEE REDUCTIONS

The application of the SGR system in 2002 resulted in a 5.4 percent reduction in physician payment rates, despite an estimated 2.6 percent increase in the costs of inputs used to provide physician services. The reduction occurred because estimated cumulative physician services spending since 1996 exceeded the target for cumulative spending by approximately $8.9 billion, or 13 percent of projected 2002 spending. In part, the payment update reflects adjustments made to the spending targets for previous years for revisions in GDP estimates and for more accurate actual spending statistics. Correcting these errors in previous years' targets and spending totals to reflect more recent data resulted in larger physician payment increases in those years than if accurate data had been used, and they contributed to the size of the reduction in payments in 2002.

The SGR system sets spending targets for physician services and adjusts payment rates to bring spending in line with those targets. Conceptually, if spending equals the targeted amount, physician payment rates are updated to keep pace with the percentage change in input prices as measured by the MEI. If spending exceeds the target, the change in payment rates is smaller than the change in input prices. If spending falls short of the target, payment rates are allowed to grow faster than the rise in input prices.

By adjusting payment rates when prior-year spending has been too high, the SGR system moderates the growth in Medicare outlays for physician services.

The SGR adjustments to the input price update are determined by how much the cumulative physician spending since 1996 differs from the cumulative spending target since then. Spending and targets must both be estimated from information available each November when payment rates are set for the following year. Previously, those estimates were then used in subsequent years. Based on requirements in the BBRA, however, HCFA implemented a process for revising the most recent two years of spending and target estimates. Because the annual targets are determined by changes in four factors—the number of fee-for-service beneficiaries, real per capita GDP, input costs, and the effect of changes in laws or regulations—a revision to any of those factors, or to estimates of prior spending, can change the spending estimate. The SGR adjustments to the input price update can then take effect because of growth in the volume or intensity of services delivered, resulting in spending deviating from targets, or because of revised estimates for prior years' targets and spending.

In setting payment rates for 2002, CMS updated its estimates of past spending and recalculated past targets. The net effect of both revisions indicated that Medicare outlays were an estimated $8.9 billion too high. The SGR is designed to recover this excess amount by lowering payment rates in 2002 and future years. CMS' original estimates of spending since 1998 were too low, in part because the agency had not included all appropriate claims in making these estimates. The original spending targets for 2000 and 2001 were too high, largely because the Bureau of Economic Analysis in the Department of Commerce revised its GDP and GDP growth estimates for those years.

To some extent, the reduction in payment rates this year corrects for inaccuracies in previous estimates that produced physician fees that were too high in 2000 and 2001. In both years, payment rates increased by more than the change in input prices because the information available at the time those rates were established suggested that physician spending had been held below the targets. In 2000, payment rates increased 5.4 percent, while input costs increased 2.4 percent; in 2001, payment rates increased 4.5 percent, while input costs increased by 2.1 percent. The reason that 2002 payment rates fall 5.4 percent while input prices increase by 2.6 percent is that the revised estimates revealed that spending exceeded the targets in previous years. The reduction would have been almost 4 percentage points greater, but the SGR system limits how much fees can be adjusted for the differences between actual and target spending.

AVOIDING LARGE PAYMENT SWINGS IN SYSTEM BASED ON SPENDING TARGETS

Several measures could moderate the fluctuations in physician payment rates. Although these modifications to the SGR could mitigate the possible impact of rate instability or reductions in beneficiary access to needed services, doing so could also lessen the ability of spending targets to encourage fiscal discipline. Available data indicate that access is adequate, but more timely and detailed information is critical to promptly recognize potential deteriorations in access.

Moderating Fluctuations in Physician Payment Rates

The SGR system is designed to limit the fluctuations in payment rates, but its design could be modified to achieve greater rate stability. The BBRA specified that adjustment to realign spending with the targets cannot cause payments to fall by more than 7 percentage points below, or increase by more than 3 percentage points above, the percentage change in input prices. In addition, spending deviations from past targets are not corrected in a single year but are spread over several years. Greater rate stability could be achieved by narrowing the range over which rates could change from one year to the next. Similarly, the corrections for spending deviations could be spread over longer periods of time.

Modifying how spending targets are set could also reduce year-to-year fluctuations in rates. Currently, the changes in GDP for a single year are used to establish the spending target. The difficulty in accurately estimating GDP has contributed to the problem of fluctuations in the target. In addition, linking annual changes in the targets to annual changes in GDP ties the target to the business cycle. GDP growth rates are higher during periods of prosperity and lower during downturns—a commonly used definition of a recession is a decline in real GDP for two successive quarters. But health care needs of Medicare beneficiaries are not cyclical. Neither significantly lowering spending targets during a downturn nor unduly increasing them in a period of prosperity is appropriate. Linking the determination of spending targets to average levels of GDP over several years would help eliminate much of the cyclical variation.

Any changes to the SGR must balance the desire for greater rate stability with the need for fiscal discipline. Spending targets create a feedback mechanism between physicians' behavior and payment rate increases. However, spending targets do not create direct incentives for any individual physician, since it is the collective behavior of all physicians that determines the payment adjustments that result from missing the spending targets. The primary value of spending targets in instilling fiscal discipline is the signal they send that affordability of the program is an important concern in establishing Medicare policies. Limiting the size of the payment adjustment for missed spending targets or to corrections in prior years' targets, and lengthening the time over which those adjustments are incorporated, could partially mute the signal targets send and erode some of the fiscal discipline they encourage. On the other hand, excessive rate fluctuations can be difficult for providers and may ultimately affect beneficiaries' access

to physician services if rate fluctuations cause too many providers to decline to participate in the program.

Monitoring Beneficiary Access to Physicians

Ensuring that the use of spending targets does not compromise appropriate access to services is a key concern. Spending targets that are updated principally by the growth in GDP and other factors may not reflect fully changes in medical care and the markets for these services. It is therefore important to monitor service use to assess whether appropriate access for beneficiaries is secured, especially if fees are reduced. Such monitoring needs to involve recent experience so that if spending targets need adjustments, those adjustments are done promptly to ameliorate any problems.

Information on physicians' willingness to see Medicare patients is dated but overall does not indicate access problems. Data from the 1990s show that virtually all physicians treated Medicare beneficiaries or if accepting new patients, accepted those covered by Medicare. According to data from the American Medical Association (AMA), 96.2 percent of all nonfederal physicians (excluding residents and pediatricians who do not normally serve Medicare patients) treated Medicare beneficiaries in 1996, an increase from the 94.2 percent AMA reported in 1994. A 1999 survey sponsored by MedPAC found that 93 percent of physicians who were accepting any new patients were accepting new patients covered by Medicare.

Payment rate decisions should not be made in a data vacuum. As health needs change, technology improves, or health care markets evolve, spending targets and resulting payment rates may need to be adjusted periodically, not by a formula designed for annual updates, but by specifying a new base year target calibrated to ensure appropriate access. Payment rates that are too low can impair beneficiary access to physician services, while payment rates that are too high add unnecessary financial burdens to Medicare. Informed decisions about appropriate payment rates and rate changes cannot be made unless policymakers have detailed and recent data on beneficiaries' access to needed services.

CONCLUDING OBSERVATIONS

The SGR mechanism uses information about physician spending in relation to cost increases, changes in the number of beneficiaries, and growth in the overall economy to impose fiscal discipline on Medicare outlays for these services. This mechanism provides a signal when spending threatens to grow out of control and in that sense is analogous to what the Comptroller General has called for in testimony on several occasions with regard to the entire Medicare program. The demographic changes facing the nation require policymakers to look ahead and assess both current and future Medicare spending in relation to the entire federal budget and the economy—first to understand the urgent need for fiscal discipline, then to make choices to ensure the sustainability and affordability of the program. A mechanism like the SGR provides a benchmark for assessing the trend in physician spending and can prompt actions to bring that spending in line with overall program goals. In assessing the options for updating

physician payments, the program's prospects for long-term sustainability should be paramount. Meeting that challenge will involve difficult decisions that will likely affect beneficiaries, providers, and taxpayers.

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This concludes my prepared statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information regarding this testimony, please contact me at (202) 512-7114 or Laura A. Dummit at (202) 512-7119. James Cosgrove, Kathryn Linehan, Lynn Nonnemaker, and Hannah Fein also made key contributions to this statement.

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